Client Information Form

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Joel Baker Counseling, LLC
Practicing At: Midtown Psychotherapy Associates
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678-948-8057

Client Name:_____
(Last) (First)

Current Date: _____/_____/_____

Date of Birth: _____/_____/_____

Age: _____

Phone Number: _____ May I leave a VM at this #? _____
(Home)

_____ May I leave a VN at this #? _____
(Cell)

Address: _____

_____

Emergency Contact: _____

Relationship to you: _____

Phone Number: _____

Address: _____

_____

How did you hear about my services?

_____

May I thank this person? (YES) (NO)

Client Information Form

Briefly describe your reasons for seeking services at this time:_____

_____

_____

_____

_____

How have you addressed this issue thus far? _____

_____

What would you like to be different in your life, as a result of therapy?

_____

_____

_____

What are your strengths?_____

_____

_____

_____

_____

Questions or concerns about therapy?

_____

_____

_____

_____

_____

Client Information Form

Problem Areas: In the following list, place a check mark next to each item, which identifies an area of concern to you. Place two checks by those items, which are most important. (You may add comments after areas checked.)

___ Anger
___ Anxiety
___ Compulsive behavior
___ Depression
___ Domestic violence
___ Education/school problems
___ Eating difficulties
___ Excessive Worry
___ Fearfulness
___ Financial problems
___ Health concerns
___ Impulsive behavior
___ Marital concerns
___ Obsessions
___ Problems with partner
___ Problems with children
___ Problems with parents
___ Panic
___ History of physical abuse
___ History of verbal/emotional abuse
___ History of sexual abuse
___ Victim of crime or assault
___ Hallucinations/delusions
___ Nightmares
___ Memories of traumatic event
___ General loss of interest or motivation
___ Other (please specify)

___ Religious/Spiritual concerns
___ Sexual concerns
___ Sexual orientation
___ Thoughts of suicide
___ Trouble making decisions
___ Unhappy most of the time
___ Use of alcohol/drugs
___ Use of alcohol/drugs by significant other
___ Use of alcohol or drugs by parent/guardian
___ Vocational goals
___ Workplace issues
___ Thoughts of harming someone
___ Impulse control (i.e. gambling sex, shopping, etc.)

_____

Academic History and Employment History:

Highest Level of Education: _____

Are you currently in school? (yes) (no)

Current employer?_____

Job title/duties
(brief):_____

_____

Hours worked per week?_____

Client Information Form

Social/Relationship History:

Relationship Status: ___ Single ___ Married ___ Divorced ___ Dating
___ Widow/Widower ___ Co-habitating

(If applicable) How long have you been in your present relationship?

_____

I identify as:
()heterosexual
()homosexual
()bisexual
()lesbian
()questioning
()other_____

Do you have children? If yes, please list their ages.

_____

_____

_____

_____

Please list the people who reside with you and their relationship to you.

_____

_____

_____

Medical History

Please list any medications you are currently taking on a regular basis, dosage of medications, including herbal supplements, and/or any special diets you are on:

_____

_____

_____

Client Information Form

Name of physician prescribing medications:

_____

Describe any illnesses, injuries and operations you have had (include dates):

_____

_____

_____

Do you have any physical or intellectual limitations?_____

_____

Family History

Who were your primary caregivers?_____

Do you have siblings? Ages? _____

_____

Who did you reside with as a child?_____

What is your current relationship with parents, guardians, siblings now?_____

_____

Any known family history of mental health issues and/or alcohol or drug abuse? If yes, describe.

_____

_____

_____

Psychological/Psychiatric History

Have you ever been in individual therapy, group therapy, or couples therapy?_____

How long? _____

Client Information Form

Name of past therapy provider(s): _____

_____

Why did you seek therapy at that time?_____

_____

Have you ever been hospitalized due to a psychological or mental health condition? (yes) (no)

If yes, please explain where and how long you were treated:

_____

_____

Have you ever sought treatment for alcohol or drug abuse or addiction? (yes) (no)

If yes, please explain where and how long you were treated:

_____

_____

Have you ever attempted suicide?_____

Are you currently having thoughts of suicide?_____

Have you ever had thoughts of suicide?_____

Are you currently engaging in self-harm? (i.e., cutting, burning, scratching yourself)? _____

Have you in the past?_____

Please indicate the extent to which you have used the following substances in the past year:

Substance Yes/No If yes, how much? How often?

Caffeine_____

Nicotine_____

Client Information Form

Alcohol_____

Marijuana_____

Cocaine_____

Heroin_____

LSD/hallucinogens_____

Other:_____

Please answer yes or no to the following questions:

During your childhood or adolescence, did either biological parent have a problem with alcohol? _____

Did either biological parent abuse other chemical substances (cocaine, marijuana, heroin, prescription drugs, etc)?_____

During your childhood or adolescence did you have a guardian or step-parent who abused alcohol or other chemical substances?_____

When you were a child or adolescent, did an adult overly criticize you, focus on your failures, yell, scream, and/or swear at you?_____

When you were a child or adolescent, did an adult punch, bite, kick, burn, or beat you? _____

When you were a child or adolescent, did someone fondle you, expose themselves to you and you felt frightened, exploit you sexually, and/or attempt sexual contact when you did not want to participate?_____

As an adult, has someone overly criticized you, focused on your failures, yelled, screamed, and/or sworn at you?_____

As an adult, has someone fondled you, exposed themselves to you and you felt frightened, exploited you sexually, and/or attempted sexual contact when you did not want to participate?_____

Client Information Form

Legal History

Are you currently involved in any legal proceedings (divorce, custody hearings, civil suit, pressing criminal charges, being charged with a crime or misdemeanor, etc.)? ___ Yes ___ No.

If yes, please explain briefly:

_____

_____

_____

Do you anticipate any such involvement in the near future? ___ Yes ___ No